JF
550

COMPLAINT BY A PRISONER UNDER THE CIVIL RIGHTS ACT, 42 U.S.C §§ 1983

Name OVERTON MICHAEL Louis
(Last) (First) (Initial)
Prisoner Number C-47370
Institutional Address CALIFORNIA MEDICAL FACILITY
P.O. Box-2000 VACAVILLE CA. 95696-2000

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

JF

MICHAEL LOUIS OVERTON
(Enter the full name of plaintiff in this action.)

vs.

HIGHLAND-HOSPITAL/EMERGENCY ROOM STAFF AS OF 6-2-1981 DR. PHAN - INDIVIDUAL CAPACITY DR. RUDAS - INDIVIDUAL CAPACITY.
(Enter the full name of the defendant(s) in this action)

CV 08 3161
Case No. _____
(To be provided by the clerk of court)

COMPLAINT UNDER THE CIVIL RIGHTS ACT, 42 U.S.C §§ 1983 & A.D.A. — USC§12201 TO 12213 504 REHABILITATION ACT.

[All questions on this complaint form must be answered in order for your action to proceed.]

I. Exhaustion of Administrative Remedies

[**Note:** You must exhaust your administrative remedies before your claim can go forward. The court will dismiss any unexhausted claims.]

A. Place of present confinement CA. MEDICAL FACILITY

B. Is there a grievance procedure in this institution?

YES (X) NO ( )

C. Did you present the facts in your complaint for review through the grievance procedure?

YES( ) NO (X) PRIVATE ENTITY - A.D.A.

D. If your answer is YES, list the appeal number and the date and result of the appeal at

each level of review. If you did not pursue a certain level of appeal, explain why.

1. Informal appeal NOT Applicable

2. First formal level

3. Second formal level

4. Third formal level

E. Is the last level to which you appealed the highest level of appeal available to you?

YES ( ) NO (X)

F. If you did not present your claim for review through the grievance procedure, explain why. THE CLAIM INVOLVES A COMMUNITY HOSPITAL

II. Parties

A. Write your name and your present address. Do the same for additional plaintiffs, if any.

MICHAEL L. OVERTON CA. MEDICAL FACILITY
P.O. Box 2000. VACAVILLE, CA 95696-2000

B. Write the full name of each defendant, his or her official position, and his or her place of employment.

DR. PHAN EMERGENCY ROOM DOCTOR HIGHLAND - HOSP
DR. RUDAS 1ST YR RESIDENT - "1981" - E R. HIGHLAND HOSP.

III. Statement of Claim

State here as briefly as possible the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate numbered paragraph.

FACTS.

PLAINTIFF STATES THAT IT IS A FACT THAT PLAINTIFF WAS CONVICTED OF 2nd DEGREE MURDER W/ USE INJICE, OF PLAINTIFFS WIFE; IT IS ALSO A FACT THAT THE TREATMENT OF MRS - QUERTON WAS "FAR BELOW" THE STANDARD OF CARE GENERALLY Applied To HOSPITALS. SEE EXHIBIT 1. To 6

PLAINTIFFS IN THIS CASE ~~Exhibited~~ STATES THAT THE DR'S PHAN AND RUDAS EXPRESSED GROSS NEGLIGENCE AND MEDICAL MALPRACTICE IN TREATING MRS QUERTON.

IV. Relief

Your complaint cannot go forward unless you request specific relief. State briefly exactly what you want the court to do for you. Make no legal arguments; cite no cases or statutes.

1. RECEIVE COMPENSATORY DAMAGES $20,000,000

2. PUNITIVE DAMAGES 25,000,000

45,000,000.00

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 16 day of June, 2008

Michael L. Austen

(Plaintiff's signature)

2ND TRIAL

ORIGINAL

PEOPLE V. M. OVERTON 73300

Appellant told Hahn that two weeks before the shooting Bobbie had thrown two beer bottles at his head. The police intervened, but appellant did not file charges against Bobbie. (RT 355.) In addition, appellant told Hahn that in October, 1980, right after appellant got out of jail, he went home and Bobbie assaulted him with a hammer. Appellant did not make a report of that incident, however, later dropped the charges. He and Bobbie separated in February of 1981. (RT 357.)

The Defense

Dr. John G. West testified that he is a physician, surgeon, and trauma care expert, who has served on a number of commissions charged with evaluating the quality of currently available trauma care, and with setting trauma care standards and guidelines for doctors and hospitals in the State of California. (RT 492-494.) He examined all the medical records maintained by Highland Hospital regarding the treatment of Barbara Overton. (RT 495.)

West testified that Overton received substandard medical care which was "far below" the standard of care generally applied to hospitals, such as Highland, which are community trauma care centers. (RT 496.) In his opinion, the hospital's failure to treat Overton was a direct cause of her death. (RT 511.)

The medical records indicate that Overton arrived at Highland at 7:46 p.m., 23 minutes after she was shot.

EXHIBIT #1

(RT 497, 499.) At that time her vital signs were taken, IV's and a catheter were inserted and she began receiving blood. She was also given an abdominal x-ray. (RT 498.) The examination of Overton revealed that she had suffered a low velocity gunshot wound, that she was in shock due to the loss of blood, and that the blood loss was rapid. (RT 499-500.) West stated that these physical signs indicated the bullet involved at least an artery and possibly a femoral nerve.[6/]

About one-half hour after her arrival at Highland (8:10 p.m.), an abdominal tap was performed which indicated Overton had blood in her abdomen. (RT 500, 519.) West testified that this was an unequivocal sign that there was a major problem (internal bleeding) and that the patient had to be operated on immediately to control the bleeding. (RT 502.) He stated that the sole purpose of the abdominal tap was to determine if such an operation was necessary, and the result here indicated it was. (RT 519.)

West testified that when a person is bleeding, there is a one hour period, known as the "golden hour" in which a doctor can successfully stem the blood loss and stabilize the patient. Generally, after one hour, a bleeding

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6. Pathologist Thomas W. Rogers testified that the autopsy of the victim indicated she had been shot once in the left thigh. The bullet struck the femoral artery and left femoral vein. (RT 182-184.) Overton died of shock due to loss of blood. (RT 189.)

Exhibit #2

patient will go into irreversible shock due to loss of blood if they remain untreated. (RT 503, 505.)

In this case, forty minutes after Overton's arrival, the treating physician, Dr. Phan, ordered a chest x-ray. (RT 499, 511.) Later, Phan ordered an arteriogram, a procedure wherein dye is injected into the artery so that a doctor can see exactly what is going on. (RT 502.) West testified that generally, it takes at least an hour to set up the necessary equipment and perform the arteriogram test. (RT 504.)

West stated that the arteriogram should never have been ordered in this case. It was medically unnecessary as the doctors already knew Overton was bleeding internally. (RT 503-504, 515.) Additionally, Overton had lost 23 minutes of the "golden hour," prior to her arrival at the hospital. Doing the arteriogram would use up the remaining minutes of the golden hour. (RT 503.)

Overton was sent into radiology for the arteriogram at 9:00 or 9:05. This was one hour and twenty-five minutes after she was shot. (RT 506.) At that time the doctor who was to perform the test was not even present; the hospital had to look for him. (RT 506-507.)

West testified that when Overton arrived in radiology, the radiologist noted she had a "thready" pulse. The radiologist became very upset and tried to reach Dr.

Exhibit #3

Phan so Overton could be brought to the operating room immediately. (RT 506.) After two attempts Dr. Phan was located. (RT 513.) Overton was in cardiac arrest by the time Phan arrived. (RT 513.)

West testified that other than the treatment Overton received immediately when she arrived, she got no additional treatment and was basically left to bleed to death. (RT 515.) West stated that there was no excuse for the delay in this case. (RT 511.)

West testified that an operation, had it been performed, would have taken ten to fifteen minutes; perhaps even less time. (RT 520) He stated that the chance of survival, had the operation been performed, was 90 to 95 percent or better. West noted that the injury in this case was "fairly straightforward," the operation was simple, and that he could not remember the last time a hospital lost a patient like this. (RT 523.)

West had also spoken with a Dr. Rudas, the first-year resident who assisted in treating Overton. Rudas was extremely critical of the care she received and told West, in his own words, that "they had killed the patient." (RT 545.)

Rudas saw Overton when she first arrived and was involved in her initial treatment. He then left to treat another patient. He assumed, at that time, that Overton was on her way to the operating room. When Rudas returned, and

Exhibit #4

learned Overton was in the arteriogram room, he got very upset. He arrived in radiology about the time she went into cardiac arrest. (RT 524.) Rudas performed external and internal heart massage on Overton. Then he opened her abdomen and tried to grab the aorta to stop the bleeding, but things had gone too far. (RT 525.)

West stated that in his expert opinion this patient should never have died. (RT 25.)

The settled record on appeal (MVJ:Exhibit C, p. 2) indicates that on cross-examination West testified that the treating physicians did not, in his opinion, intentionally harm Overton, and that if Overton had not been shot she would not have died.[7/]

David DeGarmo testified[8/] that he contacted Dr. Robert Rudas at his home in Illinois, in his capacity as an investigator for the Alameda County Public Defender. (MVJ: Exhibit B, pp. 9-10.) Rudas told DeGarmo that when Overton arrived at the hospital she was alert, oriented and

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7. The majority of the cross-examination of West is unavailable due to the loss of the reporter's notes. At the hearing to settle the record, the court adopted the prosecution's summary of West's testimony on cross-examination as constituting the settled record. (MVJ:Exhibit C, p. 1.) Appellant would point out that this summary states that an arteriogram was actually performed in this case. West's testimony on direct examination, however, is unequivocal that Overton was dead before the test could be done. (RT 506, 514.) It appears, therefore, the summary is incorrect.

8. The entirety of DeGarmo's testimony is also missing, therefore the above statement is taken from the settled record. (MVJ:Exhibit B, pp. 9-10; MVJ:Exhibit D, p. 3.)

Exhibit #5

communicative. Rudas assisted Dr. Phan with initial treatment of this patient and then left to see another patient, telling Phan he would meet him in the operating room to treat Overton. When Rudas went to the operating room, neither Phan nor Overton were there. Rudas began "yelling around" to find Phan, but was unable to find him. Then he learned Overton was in radiology. When Rudas arrived in radiology, the radiologist turned to him and asked what was going on, as Overton had no pulse. Phan was not present. Rudas attempted various life-saving techniques on Overton but to no avail.

Rudas said that Highland was a general trauma center and that if the emergency room had been properly staffed and supervised Overton definitely would have survived.

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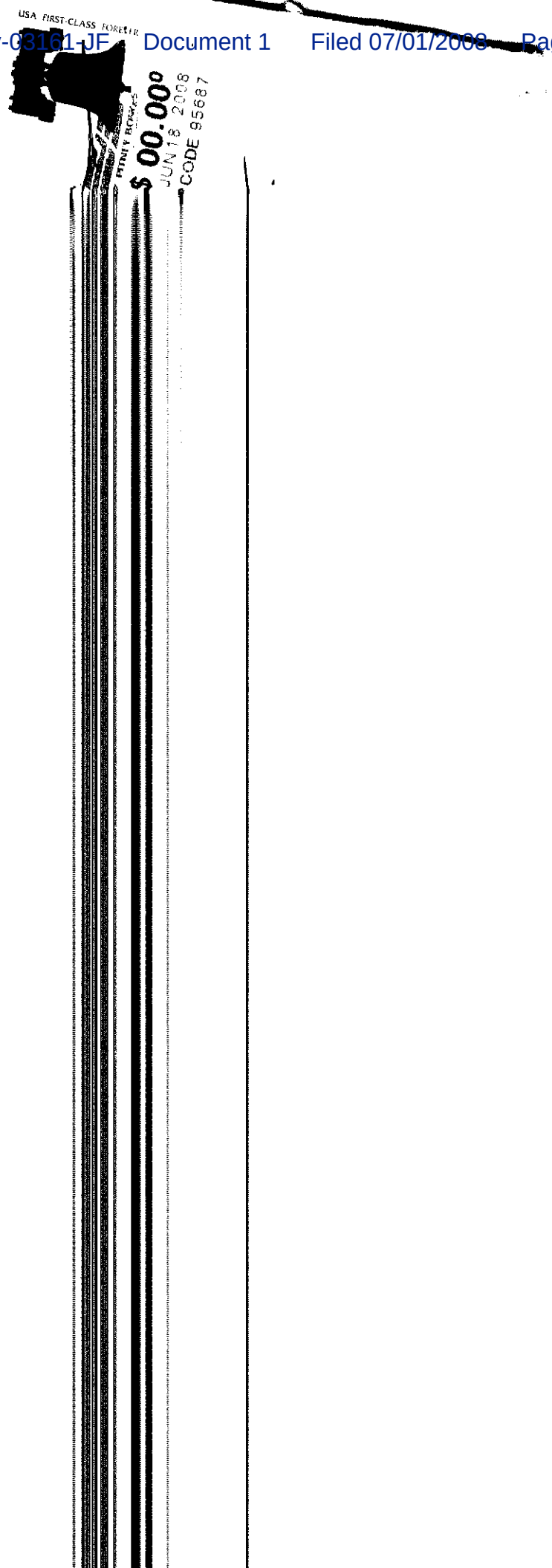
Exhibit *6


USA FIRST-CLASS FOREVER
$ 00.00
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CA MEDICAL FACILITY

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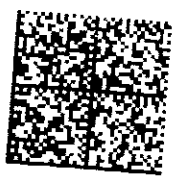

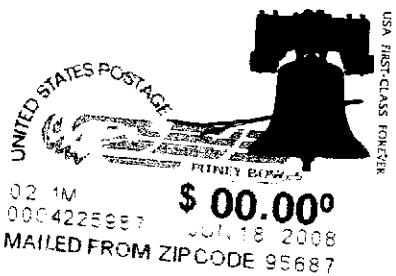

UNITED STATES DISTRICT COURT.
FOR THE NORTHERN DISTRICT OF CA.
P.O. BOX 36060
450 GOLDEN GATE AVE.
SAN FRANCISCO, CA 94102

LEGAL-MAIL